EXHIBIT 18, Part 2 of 4

transaction in a class action.

And so I had to look at this and say, you know, this is another hurdle to class certification. It's also a hurdle on the merits. Courts have been all over. And it's uncertain whether plaintiffs across the land will win. With all due respect, some might and some may not. And so that, again, Your Honor, is a litigation risk discount.

Some of the other factors that we had to consider were, the past claimants obviously have cancer. Obviously that is a health risk. And with respect to final resolution on an immediate basis as opposed to years of prolonged litigation, we viewed it as a significant benefit to have these issues resolved now, to get people money, as opposed to litigating a case that may not be certified and may not be over for years to come.

So with respect to what is the value of the settlement, Mr. Leventhal is going to address that in detail. But I want to make this point. What the settlement offers is this. It offers 40 percent of the difference between the billed amount, the high number, and what the physician will take, the low number, capped at $15,000. Well, you know, look, during the negotiation process, I tried to get concessions for

more money and I tried to get concessions of no caps. They wouldn't do it. It was a concession we had to make.

But what it really means is this, and the evidence in the briefing supports this, that the cap doesn't affect approximately 80 percent of the past claimants. And what that means, Judge, is that with respect to that 80 percent of the past claimants who participate, who will receive the full 40 percent, which is equal to or less than $15,000 of the difference, that is, in essence, two-thirds of their judgments value of the difference without regard to whether they get punitive damages or not.

A simple example is this. If the difference was $10,000, under the settlement, you get 4-. If the difference was $10,000 and a class member hired me and I litigated that case and won and got $10,000, but that client had to pay me 40 percent for fees and costs, the net proceeds is 6-.

So when you consider immediate no-risk resolution at 4,000 versus risk and delay to get 6-, if you can get two-thirds of judgment value today without risk, that's a pretty good result compared to what a possible judgment value would be.

And so I submit, Your Honor, that under Ballard

factor number one, with respect to over 80 percent of the past claimants, their recovery under the settlement is equal to two-thirds of the judgment value, without punitive damages or bad faith or penalty money, that they would get if they litigated this case privately. And when you factor in litigation risk analysis discounts, two-thirds of judgment value for 80 percent of the class as a whole is a really good recovery in a contested piece of litigation.

Now, we understand that there are certain people who have high dollar claims that the $15,000 cap affects, and we recognize it's about 20 percent of the class. The settlement is clear. The notice was unambiguous that there was a cap. And with respect to those 20 percent, we negotiated a very high opt-out tolerance because we believed that those individuals, if they so chose to do it, would opt out.

And maybe they should opt out. Some of them may have opted out. But the point is is that many of these individuals did not dispute the way their benefits were paid, had no beef with the company, and wanted to stay in the settlement. Now, Your Honor, the law in Arkansas, I think, and everywhere it's fairly clear, that the Court should not consider judgment value, should not consider punitive damages in assessing

fairness and reasonableness.

The other major factor, Your Honor, that I believe the Court shall consider was really well articulated in two documents that were attached, I think, to our brief, or to Life Investors' brief. And that is the district court's rulings in Skelton and Robertson with respect to fairness. Very long detailed rulings following fairness hearings.

And Judge Wright also captured this, as well as the district court in Metzger, and as well as the recent case -- what's the name of that case in Philadelphia? Is it Smith, that just denied cert? There is an issue, Judge, that needs to be addressed in -- and needs to be considered when deciding what is best for not just the past claimants, but -- and this is what is really important -- the class as a whole.

And the issue is that if you take the myopic view, Your Honor, that this litigation is focused solely on past claimants, then you're going to drive the bus off the cliff, and the results are going to be, as the Robertson court described, catastrophic for the entire class, and this is why. The more benefits are paid out, the higher premiums go. It is the crux of why this settlement is fair and reasonable to the class as a whole.

Mr. Leventhal is going to address this issue in detail and advise the Court of the premium dollar savings that the class as a whole will reap from this settlement. And the reason is is that moving forward, with benefits being paid consistent with the current adjusting practices -- and that is, the amount paid in full -- it is estimated that the class as a whole, over the next 10 years, will save $135 million in premiums.

Now, if this litigation was only about past claimants, which it is not, that $135 million premium savings is off the table. A few people will benefit because they're -- a few people will benefit because of the amount that they will recovery if they are stricken with cancer, will go up. But the net catastrophic effect is is that the policy book of business as a whole goes from here to here. It shrinks significantly. The lapse rate goes off the chart. And obviously, no one has affordable insurance and ultimately, the book of business can't sustain a loss ratio that is acceptable. And that's simple math, Judge. The more you pay out, the higher the premiums go.

If you look at Robertson and you look at Skelton, this issue was addressed in great detail. And those courts concluded, and what we're asking Your Honor to

conclude is, is that this settlement provides really the only rational, reasonable balance between past claimants who want money and premium payers who pay into the system to pay people who get cancer. Any other way that this litigation would be resolved, especially if it would be resolved requiring the defendant to pay the higher amount, is going to result in unsustainable policy lapses.

So we had to consider all of this. And I think all of these are litigation risk factors and practical factors, Your Honor. Practical factors that the Robertson court and the Skelton court really focused on and we urge Your Honor to focus on in determining that when you look at the strength of the case for the plaintiffs on the merits balanced against the offers made in the settlement, then you will understand, as I believe you do, and that Your Honor will rule that the settlement is fair and reasonable and actually does balance the interests of the past claimants with the premium payers.

Ballard factor number four, Your Honor, is the amount of opposition to the settlement. Well, there were over 250,000 putative class members, who are now actual class members who received notice. That's a pretty big number. As we sit here today, according to

our count, there are about 11 objections. Many of them are by objectors who are represented by counsel who have competing claims. I've been in that situation. I understand the objections. But it's a paltry number, Judge. There were only 476 opt-outs, 10 percent of them represented by counsel. It's an insignificant number.

The law is pretty clear that you can make some pretty good assumptions and inferences from the lack of opposition. And we would submit, Your Honor, that the lack of opposition in this case is, in essence, a clear message from the class that they like this settlement and they like it for a number of reasons. Number one, because it ensures lower premiums and affordable coverage for those class members who are not in claim status. And number two, the vast majority of those class members who are in or were in claim status don't disagree with it because they either accept the company's adjusting practices as correct or understand that in order to keep these policies financially viable, this is the way it needs to be. It's especially true, given the fact that the litigation history has been relatively sparse, considering the number of past claimants. So Your Honor, we would submit that Ballard factor number four weighs heavily

in favor of approval of settlement.

Shifting gears slightly, Your Honor. Some of the objectors have raised this issue, and I want to address it not only in anticipatory response, but also as part of the fairness hearing. There was no fraud. There was no collusion. There was no reverse auction, period. It does not exist.

How can you tell, especially in a case that appears before Your Honor without a long litigation history? Well, you can tell in a number of ways. Number one, look at plaintiff counsels' CVs. Look at plaintiff counsels' affidavits. Look at our submissions. You can see, Your Honor, that we've been involved in really fairly unpleasant, noncordial litigation with defense counsel for now about two and a half years.

Look at the docket sheet from the Pipes case before Judge Pipes -- before Judge Wright. We did an adequate amount of discovery. We litigated this case on five or six fronts. We were the first to tee up the class cert against Life Investors, and we didn't win. But we were pretty far along and pretty well knew what the landscape was.

Look at the chronology of how this deal was reached. The first time we ever met with defense

counsel was on October 6, 2008, in New Orleans, well before the Pipes ruling, which came out, I think, on November 25th, 2008. We mediated this case for two days before a retired federal judge on November 20th and November 21st down in Florida, again, before the Pipes ruling came out.

Negotiations were fairly mature and well on their way. And, you know, during these negotiations, I had a pretty good wish list of things I wanted. I couldn't make them pay. The mediator couldn't make them pay 100 cents on the dollar and freeze premiums. We're all back to litigation risk discount. We all had to make concessions.

And Judge, maybe they can address this. But I suggest that the reason that the defendants chose our firms to negotiate with was not because there was some reverse auction dynamic and not because the Pipes case some kind of way weakened our position, but because we had more cases that were more advanced. We represented more people around the country than any other lawyer in this litigation against Life Investors. We presented the greatest risk to them.

Even after the Pipes case, I remember telling Mr. Leventhal, "All right. You got one. Maybe you'll win it, maybe you won't," because I felt pretty good on

appeal that Judge Wright was just wrong. No pun intended. But we also had other cases that we were ready to tee up for class certification.

And to his credit, Mr. Leventhal conceded that, you know, the Pipes ruling was not the end of the litigation road. This case was not finished in terms of a agreed-upon settlement until, I want to say, March or February of 2009. That's about six or seven months of pretty hard-fought negotiations. We had another face-to-face negotiating session, I think, on January 2nd, 2009, in Florida.

These were hard negotiations, Judge. It was a mediated case. The mediation didn't work. Both sides were entrenched. Both sides dug in. This is the epitome, Your Honor, of an arm's length transaction by knowledgeable, well-informed, experienced counseling.

There was no reverse auction because we were the only firm, to my knowledge, that was involved in the negotiations. And we submit, Your Honor, that the settlement has a presumption of fairness and a presumption of reasonableness under the law because it was the result of arm's length negotiations by experienced counsel.

Your Honor, there is some other pending motions for fees and costs, but I suspect that that should

wait, with Your Honor's permission, until after the fairness hearing. I may have some additional substance to add, but I would like to tender the floor to Mr. Leventhal unless Your Honor has any questions.

THE COURT: Not at this time.

MR. BOHRER: Thank you, Your Honor.

MS. McCABE: Your Honor, may I approach?

THE COURT: Sure.

MR. LEVENTHAL: Good morning, Your Honor. Markham Leventhal from the Jorden Burt Law Firm on behalf of the defendants. I'd like to spend a little bit of time on the background of the dispute and the facts and the -- really, also the background of the litigation leading up to the settlement.

The Court has heard some of this before, but I want to -- I want to make sure that the Court, as it evaluates this settlement, really understands the nature of the policies, the nature of the dispute, and the nature of the litigation. As the Court is well aware, the settlement involves cancer policies, sometimes referred to as specified disease policies. And these policies generally pay benefits directly to the insured. They're a type of health insurance policy. And they pay those benefits even if the insured is covered by another health insurance policy,

is covered by Medicare.

And most of the benefits in the policies are sort of noncontroversial. They pay specific amounts, $100 a day in the hospital, $150 a day for a lab test, X dollars for certain, you know, types of surgeries. And some of the benefits are paid based upon the actual charges for the services rendered.

And there are really four types of actual charges benefits in these policies. One is chemotherapy. Radiation therapy is another. Blood work, and then an ambulance service. Chemotherapy and radiation therapy are the more significant items.

So what are the actual charges? I mean, that's what all this comes down to. And when these policies were originally issued over 30 years ago now in the '70s, it wasn't a difficult question because doctors were sending out bills. Patients were paying the bills. Patients were taking the copies of the bills, sending them in to the insurance company, and we were paying the amount that was being billed and the amount that the doctors were being paid.

So what happened? Fast-forward a couple of decades. And a lot of this, by the way, is covered in one of the expert affidavits in the record. The expert affidavit of Professor Glenn Alan Melnick, who is the

current Blue Cross of California chair at the University of Southern California. He's one of the leading experts on health care issues in the country. And he talks about the changes in health care billing practices over time.

And hospitals in particular, and also, in today's world, pretty much all physician groups began to develop a second set of prices. And we know today that all hospitals have what is called a charge master. What is a charge master? It's basically a maximum price list.

The thing about it is, though, that nobody actually really ever pays the prices on those lists. Those list prices are dramatically inflated, and let me give you one example. We had a insured who went to the hospital for 33 days. Now, the person was covered completely by a Blue Cross plan, so didn't pay any money for the hospital stay or any of the medical expenses, and never got a bill.

So what did he do? He went to the hospital and he said, "Can you give me a computer printout of, you know, all the services that you have performed during the last month or so?" And they gave him about 100 pages of computer printout that had all the services, and all of their list prices added up to $540,000, over

half a million dollars. He took that 100 pages, submitted it to Life Investors and said, "Pay me the actual charges." Now, again, the policy only pays actual charges for certain things, chemotherapy, radiation therapy. But the point is, he used that computer printout calling it a bill, asking the company to pay the actual charges for the items that were covered based on those list prices.

Well, what were the actual charges? It turns out the hospital actually got paid $67,000 for that entire hospital stay, not over half a million dollars. The list prices were over eight times the amount that was actually being charged and paid in that particular case. Now, that is an extreme example. But it's not uncommon for list prices to be double, triple, five times the amount that the actual doctors are being paid and collecting and agreeing -- they've agreed to accept as full payment for their services.

So what happened here? How did we develop all this litigation? Why are the list prices even important? Because these policies are subject to premium rate increases, just like other health insurance policies. And in the year 2004, the company had just filed for a 30 percent rate increase across the board, and was projecting that based upon what was

happening here, they were going to have to increase premiums 30 percent a year pretty much off into the future, as far as the eye can see. And they said, "What is going on here? Why do we need to increase premiums like this?" So they started an investigation.

They looked at all the policies and they discovered that the insureds were submitting statements like this computer printout that were not really bills, and that the company was overpaying the benefits for actual charges. It wasn't paying the actual amount that was being paid to the doctor, that was being charged. And it wasn't being -- paying the actual amount that, in most cases, were the legal limit of what the doctor could charge.

For example, in Medicare. As a matter of federal law, the doctors cannot bill or charge over a certain amount. Yet the company was paying, in many cases, more than that amount because insureds were submitting statements or documents showing these list prices. In many cases, these documents would say right on them, "This is not a bill." But the company was accepting them in error.

So what was to be done about this? There was unanimous agreement amongst the people looking at this that the company was overpaying the benefits, that it

was committing error because these policies insure for loss incurred. They pretty much equate actual charges with expenses, and these were not real expenses. They were not real losses incurred.

So the issue became, "Are we going to continue to increase premium rates for the policyholders as a whole, you know, for eternity? What is going to happen to the policyholders? How are they going to be able to afford this? Or do we correct what we believe is a plain error? How do we correct it?" Well, we would have to send notice to the policyholders. We would have to tell them to submit the right kind of documentation when they're filing claims. And that's what the company did.

The company decided in 2005 that it was going to correct the procedures. It sent out a letter in early 2006, and a copy of this letter is in the record. It's attached to the affidavit of Connie Whitlock, I believe, as Exhibit G. It's also cited in our brief. And it's no secret the letter went out to the policyholders. It explained plainly what list prices were. It said the company does not consider list prices to be the actual charges. And it said that going forward, please submit the proper documentation to show what the actual charges are, what is actually

being paid to these doctors. And a letter also included new claim forms, instructions, and then gave advanced notice. It didn't say this was going to take effect immediately. It said it was going to take effect in April or May of 2006.

So in April or May of 2006, this correction to the claims procedures took effect. And that's what everybody is complaining about in all of this litigation. They're saying the company didn't have the right to correct its claim forms and procedures, that actual charges should really continue to mean list prices, and that's what the litigation mostly is about.

The policyholders as a whole, most of them didn't complain about the letter. They got the letter explaining what actual charges meant, and we believe that most of them agreed with the letter. Plaintiffs' lawyers don't agree with that. Who did complain? The people that complained primarily were the people who had already been overpaid list prices, and they wanted to continue to get as much money as they could. They wanted to continue to be paid more than their doctors were being paid. And they said, "You paid me this way already, so you have to continue paying me this way. And it doesn't matter if it's wrong. And we think actual charges is ambiguous. And if it's ambiguous,

then it should be construed against the insurance company." And that, in a nut shell, is what the claim is made in almost all of these lawsuits.

Now, I said that most of the policyholders did not complain about the letter or the change, and that's true. Out of the 250,000 notices that were sent out, I believe in one of the affidavits, possibly the affidavit of Stephen Goodwin, the number of past claimants is 5,825. So out of the 25,0000 settlement class members, 5,825 are people who, after April or May 1st of 2006, had some claims paid for actual charges benefits from that date up through the date of this Court's preliminary approval order.

There was an objection sent in by a woman named Audry Hunter, and that objection is quoted on page 57 of our brief. And it says, "I have no objection with the plan paying actual charges for medical services according to one of the proposed settlement features. This seems fair and reasonable. But constant increases in premiums is not fair and reasonable." She's saying she has no problem being paid under her policy according to how actual charges is defined in the settlement, but her problem is the premium increases. And I think that's telling. So we went over who the policyholders were that did complain. Let's talk about

the litigation that ensued.

In 2007, there were three class actions filed. One of those class actions was the Pipes case here in the Eastern District of Arkansas, filed before Judge Wright. Then there was a case called Gooch in Tennessee. There was a case called Smith in Pennsylvania. All the cases pretty much argued the same thing, actual charges, you know, should mean list prices. Of course, they don't like to call them list prices. They like to say the billed amounts. We like to say -- calling them billed amounts when they're not really billed is a little bit inaccurate. And to this day, we still disagree with that.

So we have the Gooch case, we have the Smith case, and we have the Pipes case. At a time when there were, I think, seven total cases, we filed a motion before the federal judicial panel, a multi-district litigation. We asked for all the cases to be consolidated here before Judge Wright. The plaintiffs in the Gooch case and Smith case adamantly opposed that.

Now ironically, they didn't want to consolidate the cases so they'd all be together and perhaps the settlement would have included everybody, but they wanted to stay separate. Now, ironically, they're

doing everything they can to stop the settlement. Now, class counsel in this case file a bunch of additional cases. Pipes was their first case. They filed a total of six cases. They had four class actions. They had two class actions in Arkansas besides the one before Judge Wright.

They had another one against Transamerica before Judge Hendren. They had a case -- a class action before Judge Tarnow in Michigan. They had another class action in Mississippi before, I believe, Chief Judge Wingate. And they had two cases in Louisiana that at any time, they could have converted into class actions.

So the point is that these lawyers, who we ultimately settled with, had more cases than anybody else. They had more class actions. And as they said, their case before Judge Wright was far more advanced than anybody else. So naturally, we went to them to talk about settlement.

Does that mean there was collusion or a reverse auction or any kind of -- no, it doesn't. And we've been over the arm's length nature of the discussions in this case. You don't mediate before one of the leading class action mediators in the country, Judge Politan, former district judge from New Jersey, if you're

planning to come up with some sort of collusive settlement.

So we've been through the negotiations. Let me outline some of the terms of the settlement. There are three types of monetary benefits in the settlement. And when I'm done, Ms. McCabe is going to come out and go through the value of the settlement.

The first is for past claimants. We talked about past claimants. Who are they? Those are the 5,825 people who had some claims for actual charges from May or April of 2006 through the date of this Court's preliminary approval order. They were entitled to file a claim and they would, as Mr. Bohrer said, receive 40 percent of the difference between the list price and the actual charges, pretty much no questions asked. We didn't require them to certify in their claim form that they disagreed with our interpretation of actual charges.

We didn't require them to certify when they bought the policy, they thought actual charges meant list prices. We didn't do any of that. We wanted to, but we compromised. All they had to do was file a claim. They will get a check for 40 percent of that difference up to $15,000, which doesn't kick in until that difference is $37,500, because it's 40 percent of

$37,500 equals 15,000. So you have to have a pretty big differential before that cap even comes into play. And when we figured it out, we had estimated that 88 percent of the settlement class would be unaffected by that cap.

I believe now, based upon the claims that were filed, it's about 80 percent. So the vast majority of those past claimants were not even affected by that cap. File a claim and get a significant check.

Now, I have seen pleadings in other cases, and maybe even some of the objections in this case, referring to that as pennies on the dollar. Now, that is just absurd. I mean, getting a check for -- this is not a coupon settlement. This is real money. File a claim, and you get a check for 40 percent of the amount in dispute and you don't even have to say it is disputed. So I don't need to spend any more time on that. Ms. McCabe will go over the value of that particular benefit.

There is two other types of monetary benefits. There is a $1,000 benefit for former cancer policyholders. These are policyholders that aren't policyholders anymore. They don't even have a policy anymore. But we provided in the settlement that they could file a claim for a $1,000 benefit. And at any

time over the next 10 years, even if they had cancer already, if they have a subsequent treatment for cancer, or even if they didn't have cancer, if they were diagnosed for cancer anytime over the next 10 years, they can get a check for $1,000.

And the last type of benefit ia a $500 benefit for people who are deceased. Deceased former policyholders, to the estates of those policyholders. They no longer have a policy and they passed away. Those are the three types of cash monetary benefits in the settlement.

I'd like to -- I think this would be a good time to do a little comparison between this settlement and the two settlements that Mr. Bohrer mentioned on cancer policy cases that have already been finally approved by other courts. And those are the Robertson settlement and the Skelton settlement.

THE COURT: Mr. Leventhal, before you do that, I was going to take a break at 10:30. Is this a decent time to do that? I think I have somebody that's waiting on an order out there. So we're going to break.

MR. LEVENTHAL: This would be an excellent time for a break, Your Honor.

THE COURT: All right. Court will be in recess

until 10:45.

(Recess.)

THE COURT: We are back on the record. Thank y'all for your patience.

MR. LEVENTHAL: Your Honor, I'm going to finish summarizing the settlement benefits before I move on to this comparison of the other actual charges settlements. We talked about the monetary relief, the three forms of the monetary relief. And there are also some components of nonmonetary or injunctive relief.

The biggest item that's a point of contention seems to be the actual charges injunction, which resolves the ambiguity that's present in all these cases and resolves it in a way consistent with five different state statutes. The injunction says that the company, going forward, will pay the actual charges in the amount equal to what is really owed either by operation of law, by agreement, or whatever, whatever is actually owed to the doctors and is accepted by the doctors as payment in full for whatever services they render. So we're referring to that as the actual charges injunction.

There are several other forms of injunctive relief. There is a provision that freezes the premium rates for one year, and there is also a provision that

triples certain lifetime benefits. Some of the policies have a lifetime cap on the total amount of benefit that can be paid out for chemotherapy or radiation therapy. The settlement reforms the contracts to automatically triple those lifetime maximums. And Ms. McCabe is going to go through a valuation of those various forms of relief.

A few points on the actual charges injunction. This is a key provision obviously, and it's amazing how this has been mischaracterized. First of all, this provision is going to save the policyholders over $100 million of premium increases over the next 10 years. So the idea that the injunction somehow harms the policyholders just cannot hold any water.

Secondly, you know, one of the factors the Court is considering is whether the settlement is reasonable. Well, a provision that pretty much parallels a statute enacted by five different states, which those state legislatures have found good enough to become the public policy of those states, can hardly be argued as unreasonable.

And indeed, we went over this before, so I don't need to repeat it, in some of the earlier motions. What happened in the state of South Carolina is telling with the Ward case, because the Ward case was decided.

The South Carolina Department of Insurance said, "This is totally out of whack with the way we've defined actual charges for the terms of three past insurance commissioners," and supported a statute and had the Ward case legislatively overruled.

So let's move now to a bit of a comparison. We're fortunate because there have been two other actual charges settlements out there. And I have a chart here entitled "Cash Payment Comparison." The first two columns are those other two settlements.

The first settlement is called Robertson v. Liberty National. It's a class action settlement in the state of Alabama. It was finally approved. Counsel in that case was the Beasley Law Firm, who happen to be counsel to Mr. Gooch, co-counsel to Mr. Gooch in Tennessee. What did they pay the past claimants? They paid them zero. They had no payment for any of the past claimants.

All they did was enact an actual charges injunction exactly like the one in this case, yet we've seen countless pleadings attacking this settlement, attacking the injunction as ratifying a breach of contract, outrageous, harming the policyholders. And yet the co-counsel for Mr. Gooch did the exact same thing in the Robertson settlement.

Now, I've probably filed half a dozen briefs, whether it's been the 6th Circuit or Tennessee, whatever, pointing that out. You know, these same lawyers who are arguing this settlement is so, you know, horrible had the same injunction in their settlement. And what response did we get? Nothing. Not one response. Just totally ignored in half a dozen briefs because there is no response. So this settlement has been finally approved, final judgment entered. It had no benefit for past claimants. And it had the same actual charges injunction.

The Skelton settlement is a case called Skelton v. Central United Life Insurance Company. Central United has probably had more actual charges litigation than any company in the country. And they had a settlement not too long ago, and it also had some past claimant relief. They capped the relief at $5,000, and they paid 30 percent of the actual amount paid as benefits.

Our settlement is a cap of $15,000. We already went over it. It doesn't affect 80 percent of the policyholders. And it is significantly more than either of those two settlements, both of which have been finally approved.

I have another chart which summarizes all three

settlements. This is a comparison on a line item by line item basis for Robertson, Skelton, and our case here, Runyan. The actual charges injunction, all of them had it. Why? Because as Mr. Bohrer said, it's the only reasonable way to settle a case like this. It's the only way that you can balance the interests of the policyholders who are concerned about having their premiums raised and those that want to be paid, you know, list prices.

You have to have a compromise. Otherwise, it just cannot possibly work. And that's the reason why all these cases have denied class certification. That's the reason why -- one of the reasons Judge Wright denied class certification, because there is a conflict of interest between the class. There is a small group of policyholders who want to be paid list prices, and then there's a vast majority of the policyholders whose only concern is the affordability of their policies. They have no interest in having their premiums skyrocket so that a handful of people can be paid more than their doctors are being paid. How do you balance that?

That's what the settlement does. It pays some benefits to the past claimants and it corrects the -- eliminates the ambiguity going forward. All the

settlements had it. Two of them have already been finally approved. This one should be, too.

Past claimant relief, we talked about Robertson didn't have any former policyholder benefit. That's that thousand dollar benefit. Skelton had a similar benefit. The deceased policyholder benefit, this is the only settlement that had that. This is also the only settlement that had the tripling of the lifetime benefit.

This settlement has a premium rate freeze for a year, which Ms. McCabe will talk about the value of that. The other two settlements had a loss ratio provision, which is their way of limiting the premiums going forward. It was a tradeoff. We chose the premium rate freeze. Class counsel agreed with that. Overall, there is no question that this settlement is infinitely better than most of those settlements which have already been approved, and final judgment has been entered in both of those cases.

THE COURT: Under the Robertson and Skelton cases, how long did the loss ratio provision affect premiums in the future?

MR. LEVENTHAL: I think they affect premiums forever. So they agreed to a loss ratio, and I believe the loss ratio stays in place. I'm not positive of

that.

The only other thing in our settlement I want want to mention, obviously we have agreed, as the settlement agreement makes clear, to pay the expenses outside of the settlement without reducing any of the benefits to the settlement class. And so with that, I think we can turn now to the actual factors for approval.

And the first thing that I want to address is the notice and the due process issues. The form of the notice was approved by the Court. This is a copy of the actual notices, of course, in the court record that went out to all these policyholders.

This is a very comprehensive notice. It is drafted in the format advocated by the Federal Judicial Center. You'll see that the table of contents has sort of a question and answer format so people can easily find answers to questions. It talks about what the lawsuit is about in detail. It explains how to exclude yourself, how to object, what the consequences are.

It gives notice of the fairness hearing. I don't think there's any question that the Court did the right thing when it approved the notice and ordered that it be mailed out.

So the question is, you know, did we do what we

were supposed to do? We retained Epiq Systems, Inc., as the settlement administrator. Epiq Systems is one of the leading class action settlement administrators in the Country. They mailed out the settlement notices on May 14th. They published the notice in USA Today on May 26th and May 28th. Twice.

They created a settlement web site, which is www.supplementalinsurancesettlement.com, which was listed in the publication notice and the written notice. On that web site, there are frequently asked questions. There are all the important dates. You can download a copy of the settlement agreement, other documents.

And they also set up the toll free dial-in number, which they fielded 18,490 telephone calls. They had a voice-activated system, and they also had live operator support. So I don't think there's any question in this case that we have a notice and a notice plan that satisfied due process and the requirements of Rule 23.

That brings us to the Ballard factors, and we have addressed many of these in our brief. And Mr. Bohrer -- we've addressed all of them in our brief. Mr. Bohrer has addressed some of them. I am going to touch on a couple of key points.

The first thing that the Court should realize is, there are some significant legal standards that apply to approval of settlements. And the first, of course, is that there is a very strong public policy and a judicial policy favoring the settlement of class action litigation. And we've cited the cases on pages 35 and 36 of our brief. By way of example, the District Court in Minnesota, for example, in White v. National Football League said, "The policy favoring the voluntary resolution through settlement is particularly strong in the class action context. Settlement minimizes the substantial burdens to the parties and the scarce judicial resources that such litigation entails."

You've got the Third Circuit that stated, "There is an overriding public interest in settling class action litigation, and it should therefore be encouraged." The 11th Circuit, "Public policy strongly favors the pretrial settlement of class action lawsuits." The 6th Circuit, "There is an overriding public interest in favor of settlement." The 7th Circuit, "Federal courts naturally favor the settlement of class action litigation." So you have an overwhelming public policy in favor of settlement.

The second thing is, you also have a presumption

of fairness when you have a settlement that's been negotiated at arm's length by experienced counsel. And the cases discussing that principle are on pages 36 and 38 of our brief. Illustrating the point, there's a case called Wal-Mart Stores v. Visa, a very large class action litigation in the 2nd Circuit. The Court said, quote, "A presumption of fairness, adequacy, and reasonableness may attach to a class settlement reached at arm's length negotiations between experienced, capable counsel after meaningful discovery."

And then the 3rd Circuit expressed it in a little more detail and said, 'We have previously directed a district court to apply an initial presumption of fairness when reviewing a proposed settlement where the settlement negotiations occurred at arm's length, there was sufficient discovery, the proponents of the settlement are experienced, and only a small fraction of the class objected." And every one of those factors exist here.

I'm not going to belabor the arm's length negotiations. We've been over that. Mr. Bohrer has discussed the advanced nature of the Pipes case and the discovery. You can look at the docket of that case. Judge Wright thought it was ripe for class certification briefing. Both -- you know, counsel on

both sides are obviously experienced. And there has been a very small fraction of the settlement class who have objected. Only nine or ten remaining objectors in the case.

So to sum up, you have a strong public policy in favor of the settlement, and you've got a presumption of fairness. So you move then to the Ballard factors. They have been addressed in our brief. A couple of key points.

You know, the first Ballard factor talks about sort of balancing the merits of these different cases against the value of the settlement. And Mr. Bohrer touched on that. But one point I want to make is that when you're doing that analysis, you need to compare apples to apples. So if somebody comes in and says, "You know, I think I've got a really strong case on the merits in some other jurisdiction," that's not the comparison.

This is a multi-state class action settlement. So the issue on the merits is, what chance do you have to win, succeed, take a certified class all the way through trial somewhere else. So it's not just the merits of the individual claim. It's the merits of class certification. Winning an individual case somewhere because a court says actual charges is

ambiguous is not apples to apples.

What is the merits of class certification? Can you, you know, certify a class somewhere else? Well, the plaintiffs are 0 and 2 on certification. Judge Wright's decision, we've all heard about. Last Friday, the court up in Pennsylvania in the Smith case denied class certification. And that order is in the supplemental appendix, I believe at Exhibit 27. They're the end of that supplemental appendix. You will see the Smith order denying class certification has been included.

And let's talk briefly about the merits of an individual case on an individual basis. We know that we have now statutes in five different states that are directly against the plaintiffs' position. We also know that in the state of Alabama, there is case law against that position. In fact, after the company corrected these claims procedures -- or actually after the company decided to make the change, it took a while to actually implement it, the first case anywhere that I know of on this issue was the Clayburk decision in the state of Alabama, Federal Court, Middle District, Clayburk v. Central United, which held that actual charges was ambiguous. Unambiguous, it meant the amount that was actually paid because that's what the

loss was, and that could be the only reasonable interpretation.

Now, since that time, there were then three other district courts that decided the same way. Then you had the Ward case, which reversed one of those. Then you had a Guidry case in the 5th Circuit based on a different type of policy. And now you have a mixed bag in the case law.

Just about two weeks ago, the 11th Circuit, in a case called Philadelphia American Life v. Buckles, decided that actual charges incurred was unambiguous and could only mean the amount that was actually being paid and accepted. So now you have a split in the circuits on that issue. And the Philadelphia court actually made reference to list prices as fictional or fictitious amounts and said that were we to construe actual charges incurred to mean -- they didn't use the terminology "list prices," but anything other than the actual amount that was being paid, that would lead to an absurd result.

So the bottom line is, when you talk about the merits, you've got statutes on one side. You've got a split between the case law. And what is the case law that the objectors keep saying is, you know, on their side on the merits? It's a bunch of cases that

basically just decide actual charges as ambiguous. Some of those cases then say, "Okay. Well, then it should be interpreted against the insurance company." Other cases say, "Okay. Well, now because it's ambiguous, you have to go into this individual analysis of extrinsic evidence and what did the parties intend and sometimes what were the reasonable expectations."

So it just evolves into, like, an individual trial. But the point is, Ballard, you're supposed to compare what are the chances of getting a class certified and trying it, you know, to a successful resolution against -- and on top of all that, the expense of the litigation, how much time would it take, what kind of judicial resources would be used up in the process. So -- and that also ties into the third Ballard factor, which is the consideration of the complexity, the length, and the expense of further litigation.

What is the alternative to this settlement? What is that -- what is the result that the objectors or proposed intervenors would have liked to have had happen? Well, they would have liked an alternative chaos that would have been just unbelievable. We're going to have, what, litigation in -- throughout the country, in state class actions. We're going to have,

what, state class actions in all the different states, even though class certification has now been denied in two states? We're going to have -- we're going to relitigate the class certification issue with appeals of certification. In countless numbers of states, we're going to fight over, you know, whether these statutes are constitutional or not constitutional. We were going to have individual litigations about a term that's supposed to be ambiguous.

It makes no sense at all. It would be a massive waste of judicial effort, which is why -- that's why there's a public policy in favor of these kinds of settlements, especially in class action litigation. Because to continue them with protracted litigation, especially when you have a multi-state scenario, is just an enormous waste of party and judicial resources.

And the last fourth -- the fourth Ballard factor, Mr. Bohrer has already touched on. It sort of a no-brainer here. It's the amount of opposition. The amount of opposition is incredibly small. You have 9 or 10 objectors out of 25,000 settlement class members.

I think it's instructive to look at Ballard itself. I mean, the Ballard case was a class of 18,500, and I believe there were 17 objectors in Ballard. Here, we have a class that's ten times the

size as Ballard and is half the number of objectors. So the amount of objections, I think, is -- clearly weighs in favor of approval of the settlement. Obviously, we don't think there's any question that the settlement should be approved.

Now, as for the substance of the objections, we'll respond to those after the objectors make their arguments. I am going to turn this over to Ms. McCabe, who will take the Court through the various values of the settlement. Ms. McCabe.

MS. McCABE: Good morning, Your Honor.

THE COURT: Good morning.

MS. McCABE: My purpose here is pretty limited. The point I would like to make, Your Honor -- and most of this information is already in the record -- is what the cash value is of this settlement and what the long-term value of the injunctive relief is to the class.

Let's talk about the monetary relief first. And as you know, Your Honor, this settlement involved claim forms, which is fairly common in these types of settlements. And so there are -- there was a set amount of money that the defendants set aside as potential available to the class, and then the settlement administrator collected claim forms from the class. And from that, we've gotten some preliminary

information to estimate how much of this value has actually been claimed.

So for past claimants, we know that there were over 1,900 claim forms filed, which is a very high take rate for a settlement of this type. Over 20 percent. And although those claims have not been analyzed yet, and they will be if this settlement is given -- is finally approved, they will be analyzed and processed. And they're going to have to be processed on a one-by-one basis because these claims are fairly individualized and the company only has limited computerized data. We can compare what the --

THE REPORTER: Can you slow down, please?

MS. McCABE: Sure. The companies can compare what the past claimants submitted as their physician list prices. Those list prices were entered into the computer as the claims came in by claims examiners manually. And then we know what claims examiners paid for each benefit as an actual charge benefit.

But what the system doesn't do is, it doesn't apply annual maximums, which some of the policies have, or lifetime maximums. So those calculations are going to have to be done on a one-by-one basis. However, by comparing those two numbers that we are able to get out of the system, we do know that the estimated value

claimed by the past claimants is seven and a half million dollars. And this is actual money that is going to be paid to the class, as Mr. Leventhal stated. This is not a coupon. This is not something that they have to jump through hoops for. This is not something that I think was stated in one of the briefs that they would have to go collect a lot of documents for. All they had to do was submit a form that stated their name, address, and either a policy number, a date of birth, or a social security number so the company could identify them.

Now, the second group is former cancer policyholders. And these people no longer have a policy, but were possibly affected in the past by rate increases and perhaps dropped their policy. So this settlement permits them to register for a $1,000 -- future insurance, basically. If they get cancer in the next 10 years, even though they don't have a policy, if they registered for this benefit, they can just send in proof that they had been diagnosed and received treatment and they can receive a $1,000 check.

Of these former cancer policyholders, we've estimated that, discounted to present value and using mortality and incidence rates to assume over the next 10 years how many of them would actually get cancer,